This Level I Screening Form must be completed prior to admission into a Medicaid Certified Nursing Facility. Failure to complete this form accurately may result in Medicaid Recoupments.

PLEASE PRINT **State of Alabama Department of Mental Health** **LTC-14 Rev. 11**

Level I Screening for Mental Illness (MI) / Intellectual Disability (ID) / Related Condition (RC)

Use for Medicaid Certified Nursing Home (NH) Only

Name: _____ **SSN:** _____-_____-_____ **DOB:** _____/_____/_____

Name of current residence at time of Level I submission **Street address** **City, State, and Zip** **County**

Check Type of Residence: ❒ **NF** ❒ **Hospital** ❒ **Home** ❒ **Assisted Living Facility** ❒ **Group Home** ❒ **Other**_____

Legal Guardian, If Applicable: _____ **Address:** _____

Note: Under OBRA '87, any individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $ 5,000 with respect to each assessment.

Referral Source and Title: _____**Date:** _____

Place of Employment: _____**Fax #:**_____**Phone #:**_____

1. Does the individual have a suspected diagnosis or history of an Intellectual Disability or a Related Condition? ❒ Yes ❒ No

1a. Specify.

ID: ❒ Intellectual Disability
Did the ID develop before age 18?
❒ Unknown ❒ Yes ❒ No ❒ N/A

RC: ❒ Autism
Did the Autism develop before age 22?
❒ Unknown ❒ Yes ❒ No ❒ N/A

❒ Cerebral Palsy
Did the Cerebral Palsy develop before age 22?
❒ Unknown ❒ Yes ❒ No ❒ N/A

❒ Epilepsy/Seizure Disorder
Did the Epilepsy/Seizure Disorder develop before age 22?
❒ Unknown ❒ Yes ❒ No ❒ N/A

❒ Other Related Condition: _____
Did the Other RC develop before age 22?
❒ Unknown ❒ Yes ❒ No ❒ N/A

2. Does the individual have a current, suspected or history of a Major Mental Illness as defined by the Diagnostic & Statistical Manual of Mental Disorders (DSM) current edition? Choose **"No"** if the person's symptoms are situational or directly related to a medical condition. (e.g. depressive symptoms caused by hyperthyroidism, depression caused by stroke or anxiety due to COPD, these conditions must be documented in the medical records by a physician) ❒Yes ❒No

2a. If yes, check the appropriate disorder below.

❒ Schizophrenia ❒Schizoaffective Disorder ❒Psychotic Disorder NOS
❒ Major Depression ❒Depressive Disorder NOS ❒Dysthymic Disorder
❒ Bipolar Disorder ❒ Generalized Anxiety Disorder ❒ Panic Disorder
❒ PTSD ❒ OCD ❒ Somatoform Disorder ❒ Conversion Disorder
❒ Personality Disorders ❒ Unspecified Mental Disorder
❒ Other Mental Disorder in the DSM _____

2b. Are any of the diagnoses checked on question #2 situational or conditions that are directly related to a medical condition? ❒ Yes ❒ No
(Reminder: If the diagnoses are situational or directly related to a medical condition, do not check these conditions on #2. However, you must ensure that this information is documented in the person's medical records by the physician, for example, depression related to stroke or anxiety due to COPD)

3. Has the individual's **"Medical Condition"** required the administration or prescription of any anti-depressant, anti-psychotic, and /or anti-anxiety medications within the last 14 days? ❒ Yes ❒ No

3a. If yes, list psychotropic medications for the **Medical Condition**
(Do not list PRN medications):_____
_____

4. Is there a diagnosis of Dementia, Alzheimer's or any related organic disorders? ❒ Yes ❒ No (Note: If yes is checked, Dementia **must** be documented in the medical records by a physician)

4a. If yes, complete the MSE. *(If unable to test due to Dementia, enter "0" as a valid MSE score; if unable to test due to any other condition, check unable to test, and leave MSE score blank)*

Provide MSE Score: ____ Check if unable to test: ❒

4b. If #4 is yes, check level of consciousness:
❒ Alert ❒ Drowsy ❒ Stupor ❒ Coma ❒ N/A

4c. If #2 & #4 are yes, which diagnosis is primary? :
❒ Dementia ❒ Mental Illness ❒ N/A
(The primary diagnosis must be documented in the medical records as "primary" by a physician)

5. Does the individual's current behavior or recent history within 1 year indicate that they are a danger to self or others? (Suicidal, self-injurious or combative) ❒ Yes ❒ No

5a. If yes, explain: _____

6. Submission of this Level I is due to one of the following:

❒ New Nursing Facility Admission

(For current NH residents, select **one** of the below Significant Changes):
❒ Medical Improvement
❒ Medical Decline
❒ Mental Illness Improvement
❒ Mental Illness Decline
❒ Behavioral Changes
❒ Short Term to Long Term Stay (only for MI/ID/RC Categorical Convalescent Care Residents)
❒ Mental Health Diagnosis Change *(i.e. New MH diagnosis)*
❒ Previous Level I Incorrect *(For NH use only)*
❒ No Level I and Determination or/and Level II and Determination upon NH admission *(For NH use only)*

7. Select Long Term Care or the applicable Short Term Care Option:

❒ Long Term Care

Short Term Care with the intent to return to the community after:

❒ Convalescent Care-Applicable for patients with or without MI/ID/RC diagnoses

For MI/ID/RC patients (1) you must have PT and/or OT orders as prescribed by a physician for 5x a week for 120 days or less (2) is not a danger to self or others and (3) must be **currently in the hospital w/ a direct admission into the NH.**

❒ Respite for no more than 7 days & is not a danger to self or others **(Respite is not reimbursed by Medicaid under the NH Program)**

❒ NH admission for an emergency situation requiring protective services by DHR, person can not be a danger to self or others, if admission will exceed 7 days, the OBRA office must be contacted immediately to prevent non-compliance **(Not applicable if currently in a hospital or other protective environment)**

❒ Other Short Term Stay (If applicable, persons with MI/ID/RC must have the Level II completed prior to admission)

❒ IV Therapy ❒ Wound Care ❒ Diabetes Care ❒ Home (in community) Convalescent Care

❒ Other (please specify)_____

8. Is this individual terminally ill (life expectancy of six months or less), comatose, ventilator dependent, functioning at brain stem level or diagnosed as having Cerebella Degeneration, Advanced ALS, or Huntington's Disease as certified by an MD? ❒ Yes ❒ No